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KANSAS HEALTH POLICY AUTHORITY

2009 Medicaid Transformation Program Review
HealthConnect Kansas

Description

HealthConnect Kansas (HCK) is a primary care case management program established in 1994 to provide Medicaid beneficiaries increased access to quality care and continuity of service, while controlling costs for specialty care. Case management was instituted by contracting with Primary Care Case Managers (PCCMs) to provide primary care to HCK members and coordinate their specialty care.

Prior to the implementation of the HCK program, a demonstration program called Prime Care Network (PCN) existed in six Kansas counties. PCN began in 1984 but expansion in other counties proved difficult. Medicaid consumers were mandatorily enrolled in the program but the state had an inadequate number of providers to meet the access needs of the consumers. The PCN program migrated into the HCK program and non-physician providers were allowed to enroll as primary care case managers (PCCMs), which increased provider participation.

Health care has evolved since the PCN and HCK programs began decades ago. Although the focus of HCK is to obtain access to a primary care physician and control utilization of specialized services, case management as defined today, is not provided.

The PCCM is a medical provider who agrees to provide medical care to a group of Medicaid beneficiaries, or when necessary, refer the beneficiary to another provider. According to a June 2009 review published by the National Academy for State Health Policy (NASHP), most states pay PCCM providers fee-for-service (FFS) plus a small per enrollee per month fee to cover the cost of coordinating care. In the HCK program, PCCMs receive a $2 per member per month (PMPM) fee to provide primary care to HCK members and to coordinate their specialty care. Medical services obtained by HCK members are reimbursed on a FFS basis. Beneficiaries are restricted to their assigned primary care case manager and may not receive medical services from other providers without the case manager's approval. There are some exceptions, including emergency services provided in a hospital emergency room, obstetrical care or family planning. Each HCK PCCM may contract to accept and provide services for a minimum of 10 and up to a maximum of 1,800 beneficiaries.

The following provider types are allowed to be a HCK PCCM:

- Advanced Registered Nurse Practitioners (ARNP)
- Family Practice Physicians
- Federally Qualified Health Centers (FQHC)

- General Practice Physicians
- Indian Health Centers (IHC)
- Physician Assistants (PA)
- Internal Medicine Physicians
- Local Health Departments (LHD)
- Obstetrics/ Gynecology Physicians
- Pediatric Physicians
- Rural Health Clinics (RHC)

The PCCM is given participation options which include:

- Control over the number of beneficiaries seen (caseload)
- Restriction of the age or gender of beneficiaries seen, and
- Ability to terminate services to beneficiaries for specific reasons (noncompliance, abusive behaviors)

The Kansas Health Policy Authority (KHPA) contracts directly with the PCCMs who receive the PMPM fee. HCK PCCM assignment and referrals are administered by Kansas Medicaid's fiscal agent, HP Enterprise Services (HP).

CMS is the federal agency responsible for administering Medicare, Medicaid, and other health related programs. CMS views PCCM programs as managed care, requiring HCK to meet most of the mandated requirements of a managed care organization (MCO) in the state. These include:

- Conducting provider and consumer surveys
- Making interpretation services available
- Assuring 7 day/24 hour access to a medical provider
- Emergency, urgent and routine appointments are available within CMS defined time frames
- Obstetrical appointments are available within CMS defined time frames
- State monitoring of access to providers and appointment availability

HealthConnect Kansas provides an array of services to beneficiaries with different health care needs. Populations who receive HCK services qualify for Medicaid based on falling into one or more of the following eligibility categories:

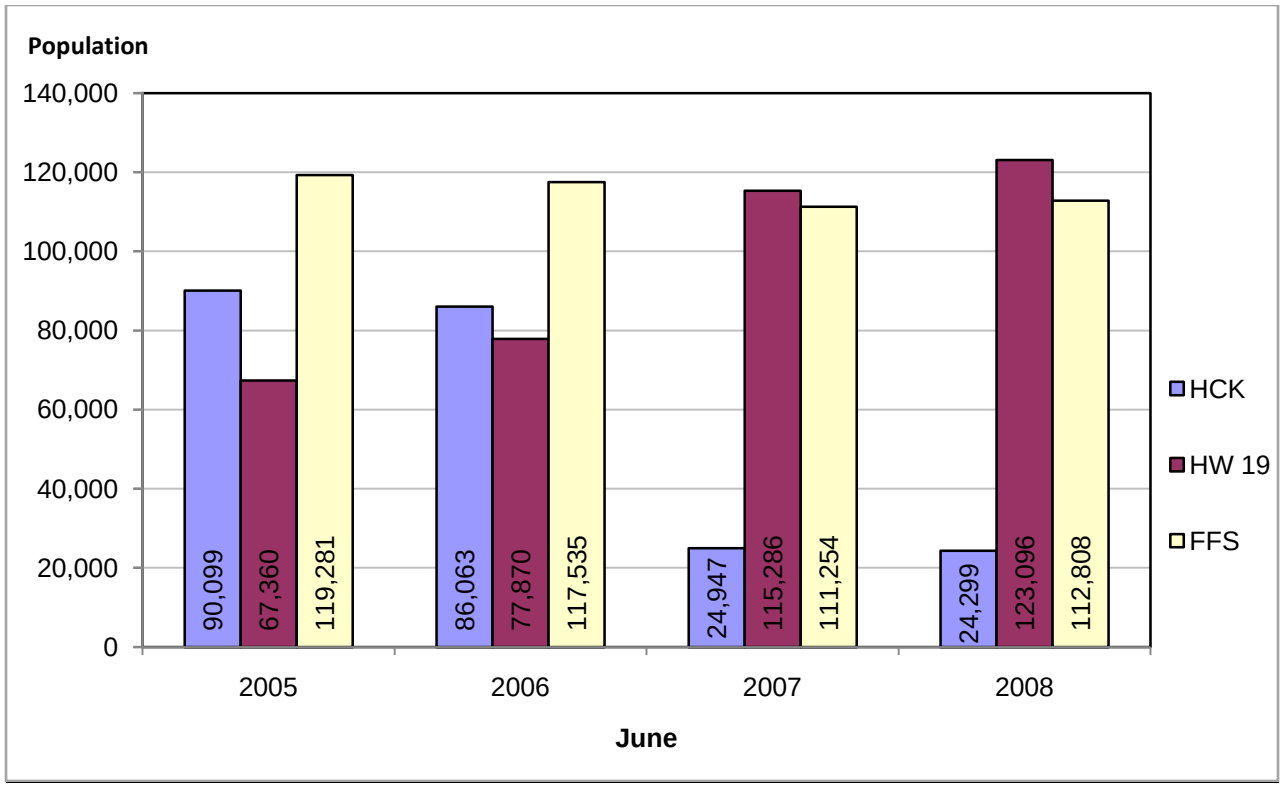
- Supplemental Security Income (SSI), a cash payment program administered by the Social Security Administration that pays benefits to aged and disabled individuals with low income and assets.
- MediKan, coverage for individuals who have a severe condition that has not yet been determined to meet Social Security Administration (SSA) criteria.
- Temporary Assistance to Families (TAF) with children under 30% of federal poverty level.
- Poverty Level Eligible (PLE) pregnant women and children with family income below 150% of federal poverty level.

Only a few changes have been made to the HCK program since it first began. These changes include:

- Referrals became paperless in July of 2005 and not tied directly to reimbursement. Providers must document the need for the referral in their medical records but do not have to submit a paper referral or a referral number in order to be reimbursed. In Kansas, most specialists will not see a beneficiary without a primary care provider referring them for treatment.
- In January 2007, HCK experienced an exodus of about 60,000 beneficiaries who were required to move to managed care organizations (MCO). TAF and PLE populations were required to join one of the two MCO's in the state, and the majority of these 60,000 beneficiaries were pregnant women and children.
- Due to budget reductions in 2009, HP managed care field representatives that provided services and contract requirement education for HCK providers were eliminated. Liaison positions were halved, leaving fewer resources for beneficiaries to use for education and advocacy. Since CMS mandates provider/beneficiary education in areas such as interpretive services and access to care, the HP managed care team and the KHPA program manager have assumed these additional responsibilities.

The Medicaid population distribution by health care program is shown in Figure 1. The decline in the number of beneficiaries enrolled in HCK following the expansion of the managed care program (HealthWave) is reflected in 2007.

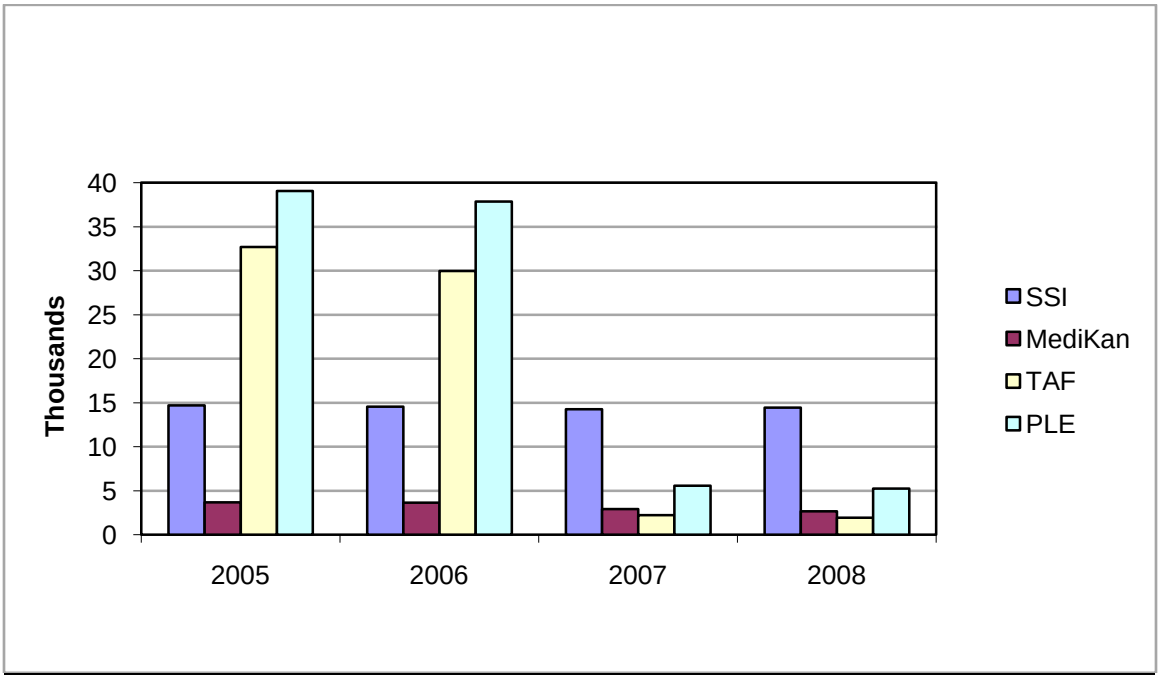
Figure 1: Volume of Enrollees by Program June 2005 – June 2008



The distribution of the HCK population, by Medicaid eligibility category, is shown in Figure 2. The declines in the TAF and PLE categories are a result of the MCO program expansion. The SSI population in HCK has remained stable while the MediKan group has declined by 31% from SFY 2006 to SFY 2008 because of the implementation of the Presumptive Disability

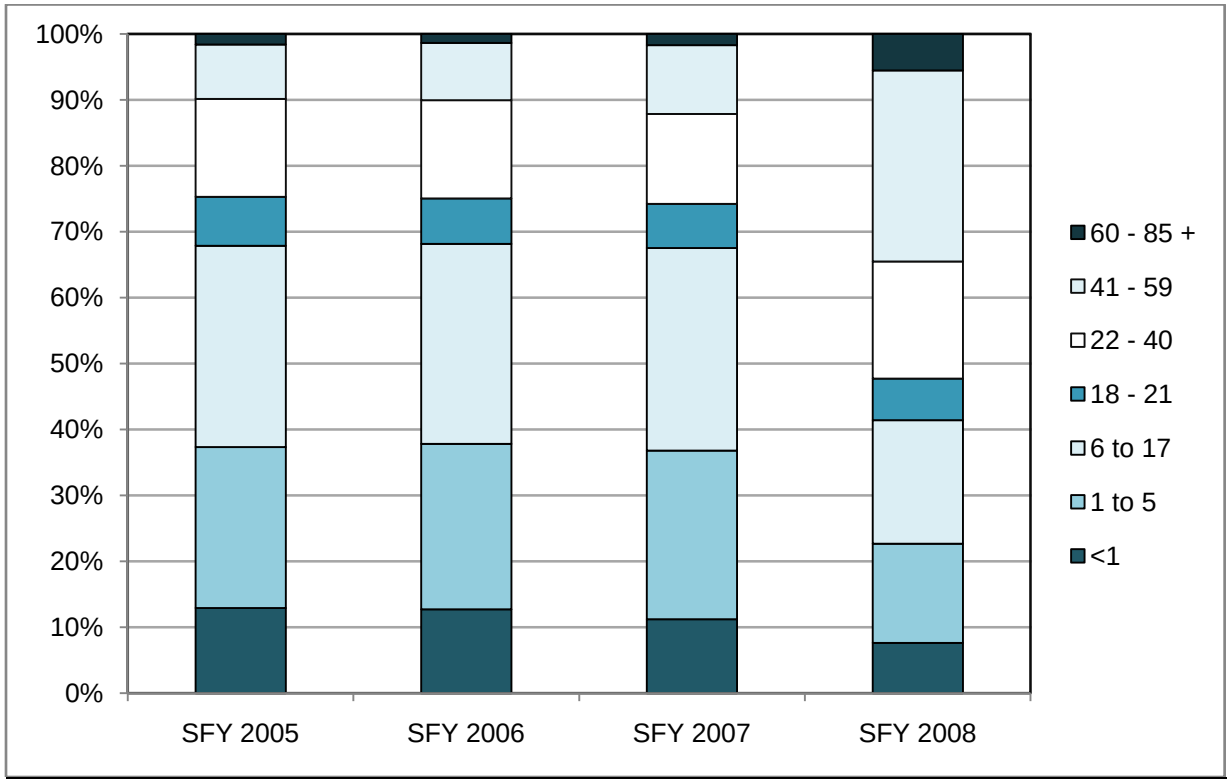
Determination Program (PDD). The PDD is a process by which Medicaid agencies are permitted to make internal disability determinations prior to a formal decision by the Social Security Administration (SSA). Applicants who meet the PDD criteria are provided full Medicaid coverage while their applications for Social Security Disability are pending, and the State is allowed to receive federal match prior to the final SSA disability decision.

Figure 2: Volume of Enrollees by Eligibility Category June 2005 – June 2008



Only modest changes in the gender or race/ethnicity have occurred over the past fiscal years, but there has been a large shift in the percentage of population by age distribution in the HCK population over the last four state fiscal years (SFY). See Figure 3.

Figure 3: Volume of HCK Enrollees by Age June 2005 – June 2008



The HCK program has primarily shifted from predominately a pregnant women and children's program to a program comprised of adults. Currently, seventy percent of the beneficiaries enrolled in the HCK program are adults who receive SSI, or MediKan and who experience a high rate of chronic disease associated with increased health care costs and utilization. Analysis of Kansas Medicaid expenditure data SFY 2005-2009 has shown an increase in expenditures of 9.2 % for the aged, concentrated in mental health and community based services spending. The same analysis shows an increase in expenditures of 29.8% for the disabled concentrated again in mental health and community based services spending. The aged and disabled populations are the highest populations in Medicaid and this is also reflected in the HCK program.

When mental illness is associated with co-morbid conditions, it increases the cost and medical complexity of care management. A study by Thomson Reuter, *Patients with Bipolar Disorder at Higher Risk for Wide Range of Physical Comorbidities was* published in June 2009, indicates bipolar patients were 1.68 times more likely to have an endocrine or metabolic disorder than were patients with no mental health diagnosis. The data was from 2006-2007 Market Scan Commercial Claims and Encounter Database.

The number and proportion of Americans who report going without or delaying needed medical care increased sharply between 2003 and 2007, according to the findings from the Center for Studying Health System Change's (HSC) nationally representative 2007 Health Tracking Household Survey, released in June 2008. One in five Americans, or 59 million people, reported not getting or delaying needed medical care in 2007, up from one in seven, or 36 million people in 2003. While access deteriorated for both the insured and uninsured, insured people experienced a larger relative increase in access problems compared with uninsured

people. Moreover, access declined more for people in fair or poor health than for healthier people. People reporting access problems cited cost as an obstacle to needed care along with rising rates of health plan and health system barriers.

Currently in HCK, there are areas in the state where adult beneficiaries have reported difficulty in finding a provider that will see them. Specific data indicating adults traveling outside of their county for PCCM services were reviewed but did not substantiate an adult access issue. A global mapping system is available to HP staff when helping a beneficiary select a PCCM, but a global mapping system is not available to identify access issues. There is no ability to map beneficiaries and the distance they must travel to locate a provider accepting new beneficiaries into their panel. A report of providers who currently will not see new beneficiaries (on "panel hold") does suggest there may be access problems for adults in specific counties. Douglas County has 50% of their PCCMs on panel hold, all of whom are family practitioners or internal medicine specialists. Sedgwick County has 72% of PCCMs on panel hold, 83% of which are family practitioners or internal medicine specialists. Shawnee County has 76% of their PCCMs on panel hold with 94% of those being family practitioners or internal medicine specialties. Family practitioners and internal medicine providers who predominantly see adults in these three counties are limiting the number of adult patients in their practices by maintaining a panel hold status.

Enhanced Care Management (ECM) was a pilot program in Sedgwick County that began March 2006, ended June 30, 2009 due to budget constraints, and was designed to provide care management to chronically ill HCK beneficiaries. Potential beneficiaries were identified from claims data based on disease states and past utilization of services. Eligible HCK beneficiaries were invited to participate in the program and participation was voluntary. ECM provided nurses and social work staff to help beneficiaries direct their own health care, such as keeping their medical appointments and filling their prescriptions, providing education on their illness/medications, and helping HCK beneficiaries' access local resources.

A formal evaluation is being conducted on the ECM program but not yet completed. Some preliminary lessons learned are:

- The ECM program was costly (over $4 million expended) yet served only 723 people over the length of the project.
- The program was set in an urban county with readily available community services; expansion to the rural or frontier areas of Kansas (90% of the state) would be more difficult due to the decreased number of available providers and social service resources, as well as the need for increased travel to access the services.
- It appears that voluntary enrollment had an impact on the size of the program; mandating the targeted population into the program would require a change in the state plan, application for a waiver from CMS, and legislative support.
- The beneficiaries who opted into the program identified significant social issues as their chief concern, rather than health conditions.

An examination of care management programs in place in other states revealed that approximately 5.9 million consumers participate in PCCM programs in twenty-nine states according to the Kaiser Family Foundation. At least five states offer PCCMs as the only managed care program option (Louisiana, Maine, Montana, North Dakota and Oklahoma). Oklahoma began offering PCCM programs as the only managed care option in 2004. Nurse care managers and social work staff were hired from the former managed care organizations in

the state to enhance care management services. A Health Management Program for high-cost enrollees was established in 2008. Oklahoma is reporting increased enrollment for children, increased provider participation, and cost reduction due to lower emergency room visits and decreased hospitalizations.

Florida, Louisiana, North Carolina and Texas have the largest PCCM programs, each with over 500,000 enrollees. According to the *Primary Care Case Management and Medicaid: 2006 Update by the Connecticut Health Policy Project*, the rationale for states moving to PCCM programs from health maintenance organizations (HMOs) were HMOs leaving the state, and the need to provide managed care options to rural areas where HMOs refused service coverage. The Governor of Connecticut ordered termination of four managed care organizations' responsibilities in November 2007 following the four companies' demands for higher reimbursement. In July 2008 Aetna was awarded the sole managed care contract for Connecticut.

Similar to Kansas, other states are focusing their attention on how to provide high quality care more cost effectively to people with complex health needs. Within this context, some states are exploring or implementing care management opportunities as a way to better address this population's needs.

A March 2008 report, *Purchasing Strategies to Improve Care Management for Complex Populations: a National Scan of State Purchasers,* published by the Center for Health Care Strategies (CHCS) provides a summary of care management efforts occurring in 12 states. The 12 states (California, Indiana, Minnesota, Mississippi, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Washington) were chosen on the basis that all have at least one program that targets SSI/AD beneficiaries for some type of care management intervention. Key findings from the environmental scan included:

- A broad range of options, including FFS and fully capitated care, are being implemented. Some programs:
  - Include SSI/AD beneficiaries within programs available to all Medicaid eligibility groups;
  - Are designed specifically for SSI/AD beneficiaries only;
  - Include a single program option (e.g., disease management) within an existing FFS or primary care case management (PCCM) structure; or
  - Have a mix of fully capitated managed care, PCCM and FFS.

- Varying substantially within and across the states are:
  - The design of the intervention;
  - The financing mechanisms;
  - The performance measurement techniques;
  - Risk-distribution; and
  - Provider and vendor contract terms.

- Common themes that emerged across the states included:
  - The impetus for moving beyond the traditional FFS approach is to increase care coordination, improve quality, and control costs.
  - Alternative funding mechanisms such as shared risk, shared savings, and pay-for-performance are being explored.
  - Although the strategies being implemented vary by name (e.g., disease management, primary care case management, medical home, chronic care

management, etc.), all have the goal of improving care coordination and increasing quality and cost-effectiveness.

Table 1: Characteristics of State Care Management Programs

State	Program Name	Target Population	Type of Program	Enrollment	Geography
Indiana	Care Select	AD and non-disabled HCBS waiver beneficiaries (excluding duals)	PCCM	Mandatory	Statewide
New York	Primary Care Partial Capitation Providers	Managed care eligible beneficiaries	PCCM	Voluntary	5 counties
North Carolina	Community Care of North Carolina	All beneficiaries	PCCM	Voluntary	Statewide
North Carolina	Chronic Care Project (pilot)	AD/SSI and chronically ill beneficiaries	PCCM	Voluntary	10 provider networks
Oklahoma	SoonerCare Choice	All beneficiaries, excluding duals, institutionalized, HCBS waiver, state or tribal custody	PCCM	Mandatory	Statewide
Oklahoma	Health Management Program	5,000 highest cost beneficiaries with chronic conditions	PCCM	Voluntary	Statewide
Pennsylvania	ACCESS Plus	All beneficiaries excluding duals, nursing home residents	PCCM	Mandatory	42 counties
Pennsylvania	Intensified Medical Case Management	Beneficiaries with chronic conditions	PCCM	Voluntary	42 counties
Pennsylvania	Disease Management	Beneficiaries with asthma, diabetes, COPD, coronary artery disease	PCCM	Voluntary	Statewide
Rhode Island	Connect Care Choice	Adults excluding duals, institutionalized	PCCM	Voluntary	Statewide
South Carolina	Medical Homes Network Program	All beneficiaries excluding nursing home, hospice, waiver programs	PCCM	Voluntary	43 counties
Texas	Primary Care Case Management	All beneficiaries	PCCM	Mandatory except for SSI children	202 counties
Texas	Integrated Care Management	SSI including duals and HCBS	PCCM	Mandatory except for SSI children	13 counties
Texas	Enhanced Care Program	Beneficiaries with asthma, diabetes, CHF, COPD, coronary artery disease	PCCM	Mandatory	Statewide
Texas	Health Management Program (in development)	Beneficiaries with high costs and/or high risk of chronic illness	PCCM	To be determined	To be determined
Washington	Chronic Care Management (pilot)	High-risk adults excluding HCBS, hospice	PCCM	Voluntary	Statewide

Source: Bella, M., Shearer, C., Llanos, K., & Somers, S. (2008). Purchasing strategies to improve care management for complex populations: a national scan of state purchasers. Center for Health Care Strategies, Inc. **Retrieved February 3, 2009 from http://www.chcs.org/usr_doc/Purchasing_Strategies_to_Improve_Care_Manageme.pdf**

One of the goals the Kansas Health Policy Authority (KHPA) has set forth is to develop and support the medical home model of care. The medical home model focuses on prevention and care coordination as a way of improving the quality of primary health care, promoting improved health status, and ultimately helping to control the rising cost of health care. During the 2008 legislative session, House Substitute for Senate Bill 81 was passed. This legislation defined the medical home in Kansas statute, as:

"a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

Improving care for high need, high cost beneficiaries with multiple chronic conditions is an integral part of service delivery within the medical home model. Because the HCK population is

composed mainly of chronically ill adults, an increased focus on the chronic medical conditions of HCK beneficiaries is important as the KHPA seeks to improve the quality and cost-effectiveness of health care while improving health care outcomes. Nationally, the aged and disabled population account for 25 percent of the total Medicaid population, but 70 percent of total Medicaid spending. In Kansas, a July 2009 evaluation showed that the aged and disabled account for 33.5% of the Medicaid population, but 71.3% of total Medicaid spending.

Many states have initiated projects to improve Medicaid and Children's Health Insurance Programs (CHIP) to advance medical homes; three such programs are highlighted below:

- Oklahoma has moved from MCOs to a PCCM model of care as stated earlier. The Oklahoma Health Care Authority (OHCA) hired 32 nurses and 2 social service coordinators to provide care management and coordination functions that previously the MCO's had performed. A Health Management Program (HMP) was launched in February 2008 and focuses on a limited number of high-cost, high-need enrollees and operates under an external vendor. OHCA is developing a medical home model that moves away from the partial capitation reimbursement approach toward one that relies on FFS reimbursement for office-based services, supplemented by care coordination payments that vary with the services offered in the practice and patient characteristics, and performance-based payments for specific preventive services and quality-related activities.

- Colorado plans to release a request for proposal (RFP) in August 2009 to design a pilot program to start in April 2010. The aim is to enroll 60,000 beneficiaries into Regional Care Coordination Organizations (RCCO) to provide care coordination functions, health outcomes management and provider support within a medical home model of care. A $20 PMPM fee will be shared by providers and the RCCO. A web-based provider health information system will be available as well as care management software support. Statewide data will be extracted to analyze and to identify data-driven opportunities to improve quality of care. A formal program evaluation will be designed to measure outcomes before the program begins.

- New York began a five year pilot project in 2008 with physicians, commercial insurance plans, and Medicare and Medicaid as participants. Electronic health records are available for physicians and standardized measures provide performance incentives from the multiple payers. Incentive payments to providers are based on process and outcomes measures derived from the aggregated administrative data received from all the health plans participating in the project. Payments are also based on the health plans achieving the structural component of the National Committee for Quality Assurance (NCQA) medical home recognition assessment tool.

Two states implementing care management programs based on medical home models are North Carolina and Vermont. Both of these states' programs are tailored to serve the SSI/AD beneficiaries. Since the primary population of the HCK program is the SSI/AD population, a closer examination of these two states models was made. These programs are described below.

Since 1998, North Carolina (NC) has had an enhanced medical home model of care in its Medicaid program called Community Care of North Carolina (CCNC). CCNC links individuals to a medical home incorporating care coordination, disease and care management and quality improvement. The key components of CCNC are:

- Local non-profit community networks composed of physicians, hospitals, social service agencies, and county health departments provide and manage care.
- Within each network, each enrollee is linked to a primary care provider to serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and provides 7 day, 24 hour on-call assistance.
- Case managers are integral members of each network who work in concert with physicians to identify and manage care for high-cost, high-risk patients.
- The networks work with primary care providers and case managers to implement an array of disease and care management initiatives that includes providing targeted education and care coordination, implementing best practice guidelines, and monitoring results.
- The program has built-in data monitoring and reporting to facilitate continuous quality improvement on a physician, network and program-wide basis.
- Payment is made to both providers and networks: $2.50 is paid to the PCCM; $3.00 goes to the network for case managers and pharmacists. (If the client is in the AD population the PCCM is paid a $5.00 PCCM fee.)
- North Carolina reimburses 95% of Medicare FFS rates.

CCNC has been expanded state wide and is the sole managed care arrangement for North Carolina Medicaid enrollees. Only one pilot project exists in the state, testing a capitated arrangement in one urban county. To date, the state has contracted for two external evaluations:

- Analysis by the Mercer consulting group found that in every year examined (SFY 2003-SFY 2006), CCNC achieved savings relative to what the state would have spent under its previous primary care case management program. Estimated savings for SFY 2006 were $150-$170 million.
- According to Kaiser in May 2009, the University of North Carolina's evaluation of asthma and diabetes patients in CCNS compared to those in the state's PCCM program found the state achieved $3.3 million in savings for people with asthma and $2.1 million in savings for people with diabetes 2000-2002. Asthma patients experienced improved care, evidenced by reductions in inpatient hospital and emergency room visits. Diabetes patients had fewer hospitalizations and higher performance measures such as primary care visits, blood pressure readings, foot exams, and lipid and A1C tests.

Vermont began a state-wide program focusing on chronic disease management and prevention and a three payer integrated medical home model in 2008. The Vermont Blueprint for Health (VBH) provides short-term intensive case management to the highest risk Medicaid beneficiaries who have one or more of eleven chronic conditions. The key components of VBH are:

- Primary care providers, hospitals, social service agencies, and community agencies partner to address the need for enhanced coordination of services for individuals with chronic conditions.
- Care coordination teams are located at social service agencies to establish relationships with primary care providers and focus on health outcomes.
- Claims data is stratified and run through a predictive modeling software tool to identify high risk individuals who are then contacted by medical staff to assess needs and develop a customized plan of care in coordination with the primary care provider.
- Care coordination teams work with a multitude of agencies and providers to focus on the individual's hierarchy of needs and psycho-social indicators of health in addition to the chronic health condition to improve and sustain health.

- VBH uses a web-based clinical tracking system with electronic prescribing capabilities and a health information exchange to ensure continuous quality improvement practices for physicians and program-wide.
- Payment is made to the both the coordination team and providers: $15 for the care coordination team per month; the PCCM receives $55 for meeting with the care coordination team to develop a plan of care, $55 for a discharge meeting to emphasize the importance of a smooth transition to a lower level of care in the program, and an additional $10 PMPM fee on top of their normal PCCM fee.
- Payment is based on National Committee for Quality Assurance (NCQA) standards. Medicaid and two commercial plans are subsidizing the program.
- The program will be evaluated on NCQA process quality scores, clinical process measures, health status measures and multi-payer claims database-derived measures. Data collected will include clinical quality, patient and provider experience and satisfaction.

Both the North Carolina and Vermont programs incorporate:

- Key partnerships between providers, hospitals, social service agencies, and community agencies
- Increased reimbursement rates
- Targeting high cost, high needs beneficiaries
- Data monitoring and reporting for continuous program improvement

Incorporating these key components into their programs is supported by recent findings. Based on research of Medicare consumers by Mathematica, completed in 2009, "*The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Beneficiaries with Chronic Illnesses",* essential components to include when designing a care coordination program are:

- Targeting of patients at high risk of hospitalization
- Staffing primarily by experienced registered nurses
- Building rapport with patients and physicians
- Responding early, comprehensively, and consistently to hospitalizations
- Managing medication
- Providing strong self-care education
- Providing social support services
- Forming communication hubs between patients and providers

Since 2006, more than 30 states have initiated projects to improve Medicaid and Children's Health Insurance Programs (CHIP) to advance medical homes.

"A medical home is an enhanced model of primary care in which teams attend to the multi-faceted needs of patients and provide whole person comprehensive and coordinated patient-centered care. First advanced by the American Academy of Pediatrics in the 1960s for certain pediatric populations, the medical home concept has evolved to embrace all populations."

Source: Building Medical Homes in State Medicaid and Chip Programs, National Academy for State Health Policy (NASHP), June 2009

Seven core features of a medical home have been agreed upon by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. These core features are:

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety
- Enhanced Access
- Payment Reform

To catalog state efforts to advance medical homes, the National Academy for State Health Policy (NASHP) recently surveyed Medicaid and CHIP directors and conducted targeted Internet research. Input provided during a working meeting with eight leading states (Colorado, Idaho, Louisiana, Minnesota, New Hampshire, Oklahoma, Oregon, and Washington), along with North Carolina and Rhode Island, further helped to identify strategies for other states to consider when developing their own plans. The full report, *Building Medical Homes in State Medicaid and CHIP Programs* (June 2009) may be found at http://www.nashp.org/files/medicalhomesfinal.pdf

Among the NASHP research findings applicable to the HCK program was that PCCM programs, such as HCK, are well-suited for supporting medical homes:

- The payment structure (i.e., FFS plus an additional per person per month fee to cover the cost of managing their beneficiaries' care) aligns well with payment reform supported by the medical home model
- The patient panel infrastructure supports a direct relationship between the primary care provider and the beneficiary (a core feature of the medical home), and also helps define the relationships and referral practices between the primary care providers and other specialists
- The existing delivery system, reimbursement and quality improvement infrastructure can be modified to better support medical homes

Service Utilization and Expenditures

In February 2009, the Department of Health and Human Services (HHS) predicted that health care costs this year will average $8,160 for every American, an increase of $356 per person from last year. The SSI and MediKan population account for 70% of the HCK total population and they are the highest cost populations in HCK. This analysis will focus on those populations.

HCK expenditures consisting of the $2 PMPM case management fee are approximately $34,000 per month or $400,000 per year. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are allowed to enroll as PCCMs but are not paid the monthly $2 PMPM fee, as their encounter rate incorporates this fee. PMPM expenditures fluctuate according to the number of HCK beneficiaries enrolled at any time; the transition of 60,000 out of HCK during 2007 decreased the PMPM expenditures.

The medical services provided to HCK beneficiaries are reimbursed on a FFS basis and these expenditures are described in greater detail in other FFS specific program reviews. The trends in expenditures for the population groups served by the HCK program are as follow:

- *TAF and PLE:* During the past four fiscal years (FY 2005 – FY 2008), the average yearly medical expenditures for the TAF and PLE populations have remained fairly constant and are close to $1,000 per beneficiary.
- *MediKan:* The average yearly cost for MediKan beneficiaries has risen from around $2,600 in FY 05 to $4,000 in FY 08, representing a 35% increase.
- *SSI:* The average yearly costs of SSI beneficiaries have increased from approximately $6,700 in FY 05 to just under $9,000 in FY 08, representing a 26% increase.

When evaluating these expenditures, it is important to note that the MediKan benefit package is limited to the provision of medical services in acute situations and during catastrophic illnesses. These acute and catastrophic events result in higher medical expenditures than for the TAF and PLE beneficiaries who are healthier but who also have access to a broader range of medical services. The increased expenditures for the MediKan and SSI populations reflect the impact of chronic health conditions that are more prevalent in the aged and disabled population.

Figures 4 and 5 display total HCK expenditures (i.e., the combined $2 PMPM case management fees and FFS claims) and the average expenditures by population group for SFY 2008. Figures 4 and 5 indicate SSI and MediKan beneficiaries are the costliest to serve in the HCK program.

Figure 4: Total HCK Expenditures by Eligibility Category SFY 2008

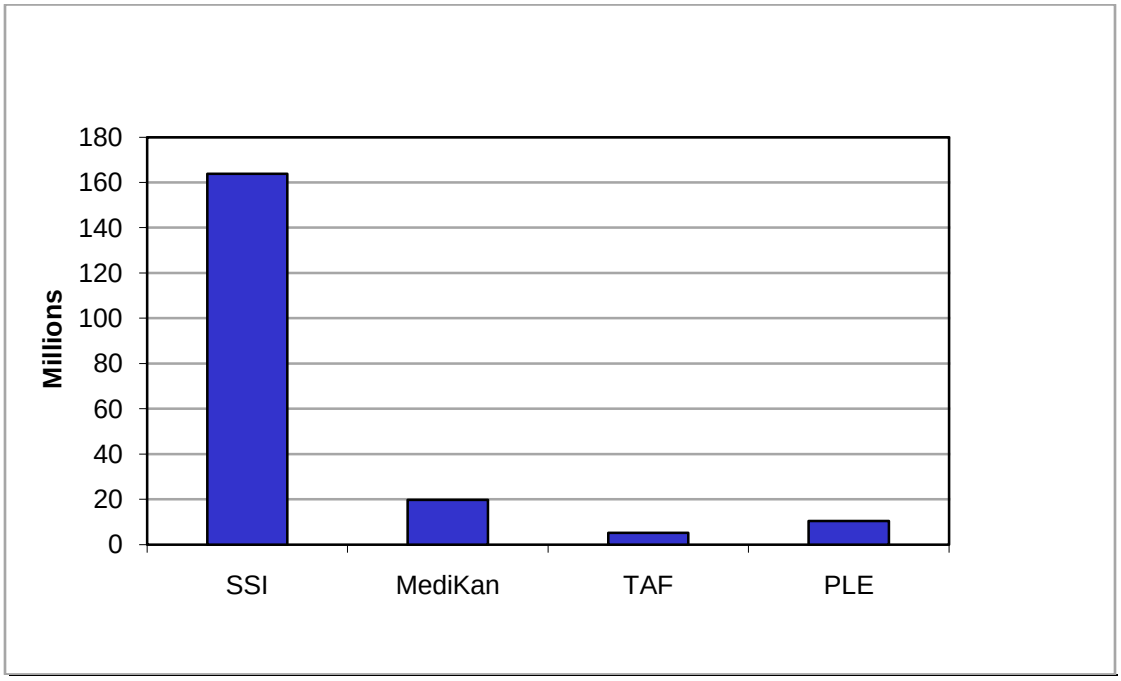
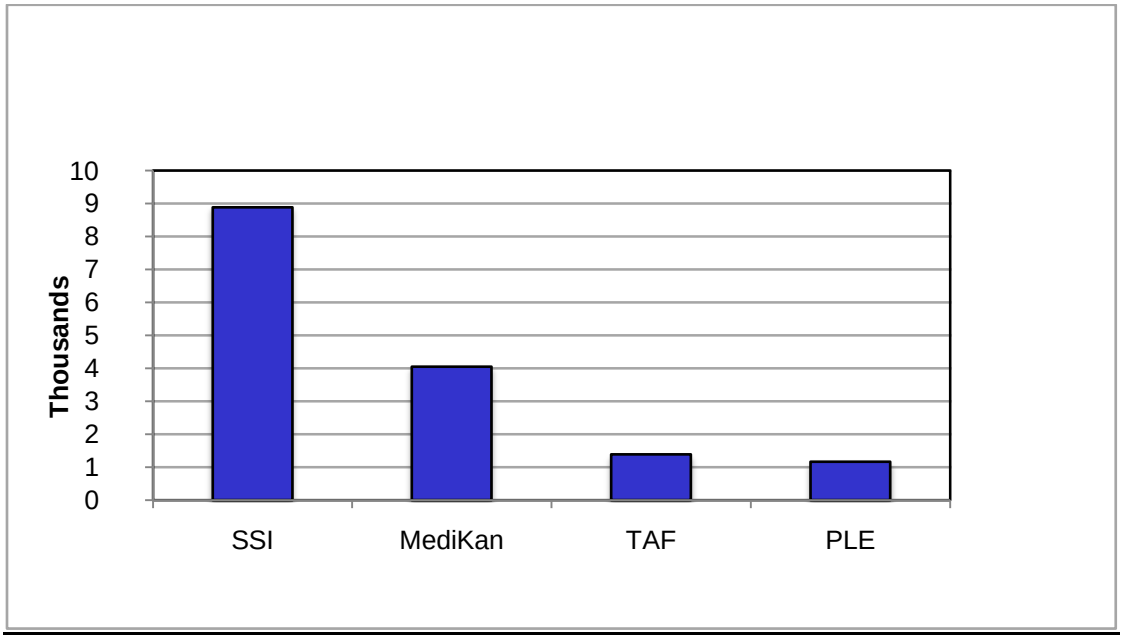


Figure 5: Average HCK Expenditures by Eligibility Category SFY 2008



Figures 6 and 7 examine the highest expenditures in HCK by category of service (COS) for state fiscal year (SFY) 2008 for the SSI and MediKan population. The highest expenditures for SSI and MediKan have remained, in this order, throughout the past 4 fiscal years.

- Medications
- Hospital Services

- Physician Services and
- Psychiatric Services

TAF and PLE highest expenditures have remained, in this order, throughout the past 4 fiscal years

- Hospital Services
- Physician Services
- Medications

During the past four fiscal years, prescribed drug costs have decreased by 25%. This reduction coincides with the implementation of Medicare Part D pharmacy benefits. Medicare Part D was implemented on January 1, 2006, with the first full year of impact reflected in SFY 07. Hospital costs increased by 9% over the past four fiscal years, closely aligning with national inflation rates. Expenditures for physician services decreased by 11% over the past four fiscal years with the transition of 60,000 beneficiaries into MCO plans likely contributing to this decrease.

Figure 6: Highest HCK Expenditures by Service Categories for SSI Beneficiaries SFY 2008

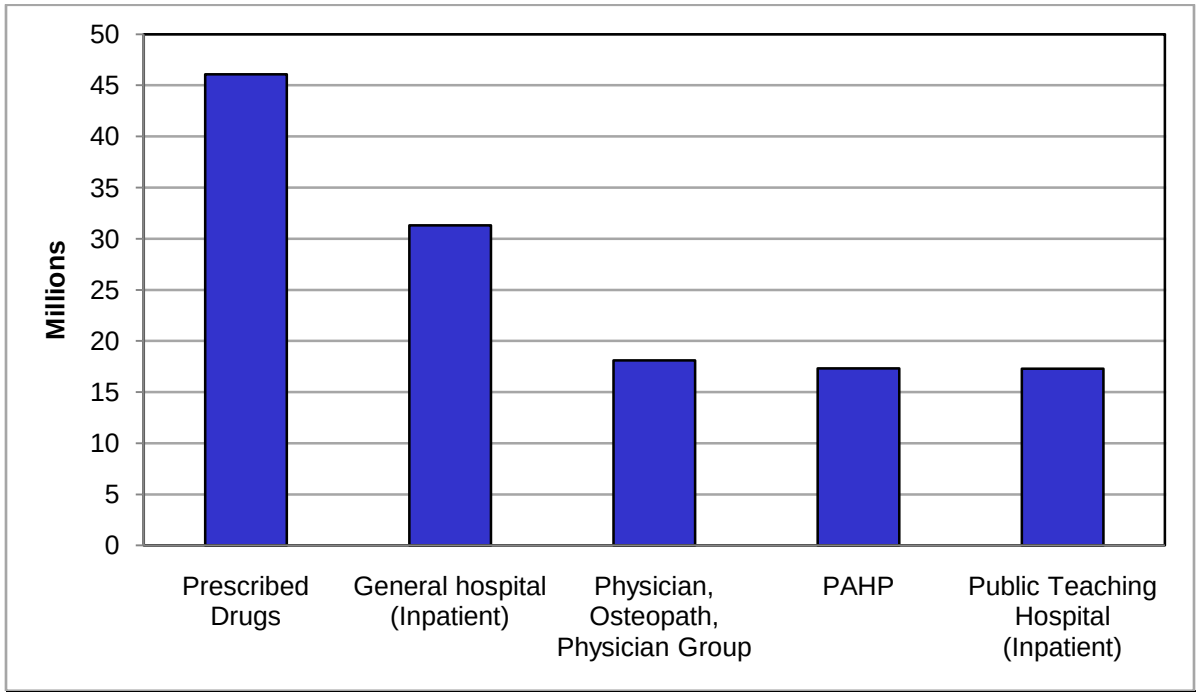
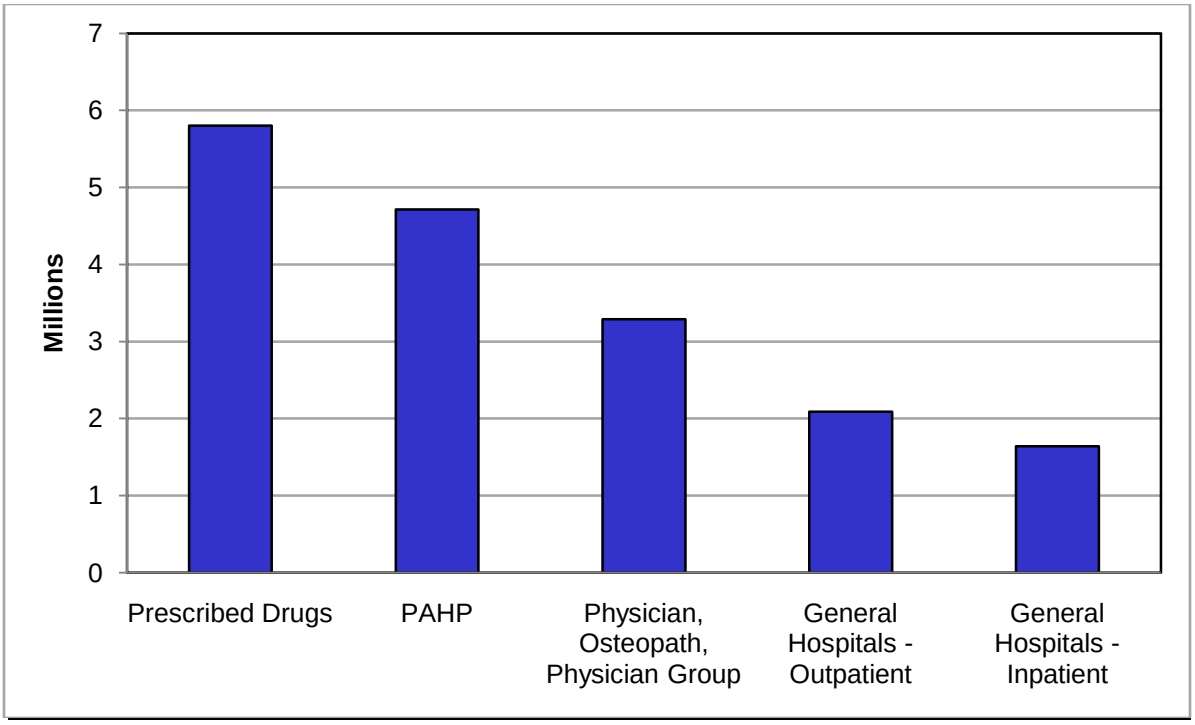


Figure 7: Highest HCK Expenditures by Service Categories for MediKan Beneficiaries SFY 2008



The most costly diagnoses experienced by HCK in SFY 2005 and 2006 reflected a younger and healthier population and included attention deficit hyperactivity disorder, routine care for children, and Caesarean deliveries. With the transfer of pregnant women and children during 2007 from HCK the most costly diagnoses are now reflective of an older population and include gastric, cardiac, and mental health diagnoses.

Expenditures for 2008 by diagnoses for SSI and MediKan reflect a chronically ill adult population except for two cases of outlier maternal anemia. These two outlier cases of maternal anemia cost over $9 million alone. Heart, gastrointestinal, joint disorders, immune disorders, and psychiatric disorders account for the top expenditures by diagnosis, see Figures 8 and 9.

Figure 8: Highest Expenditures by Diagnosis for SSI Beneficiaries SFY 2008

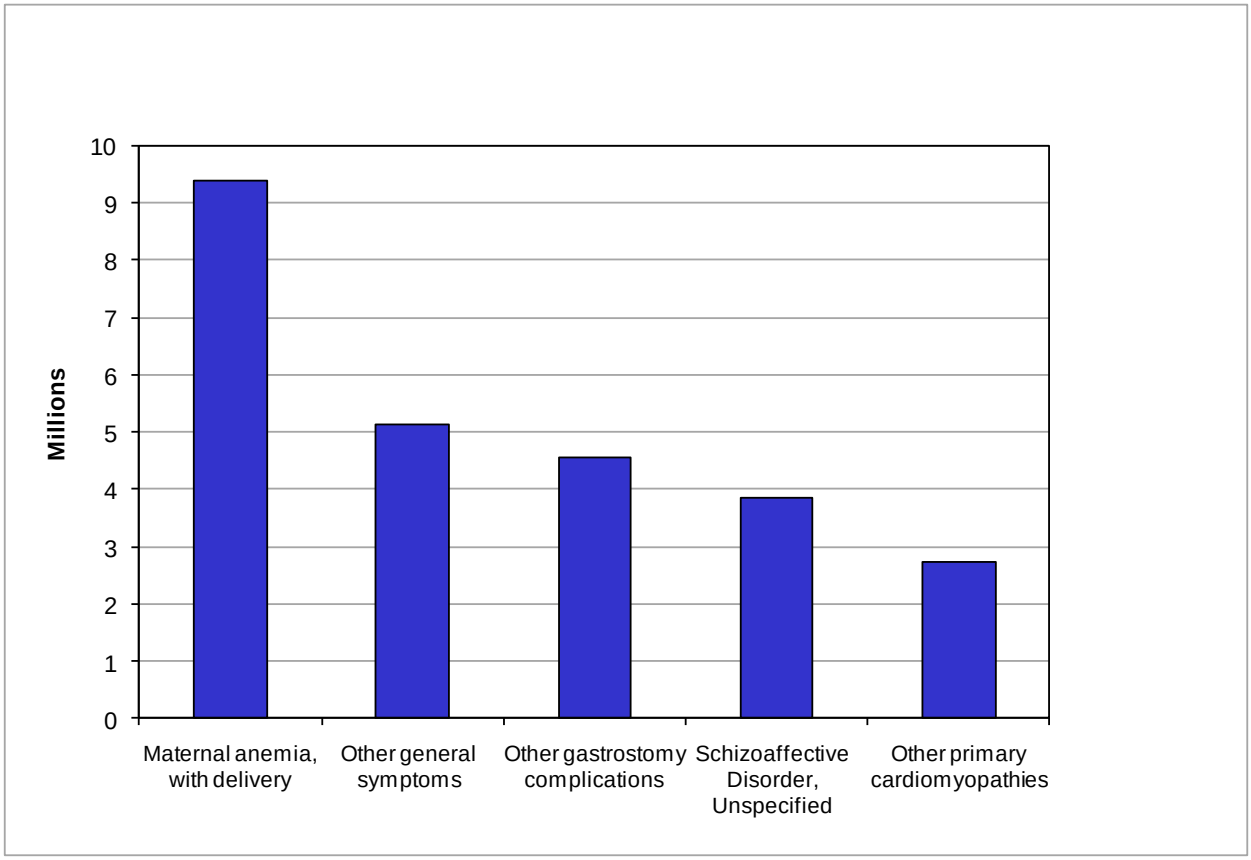
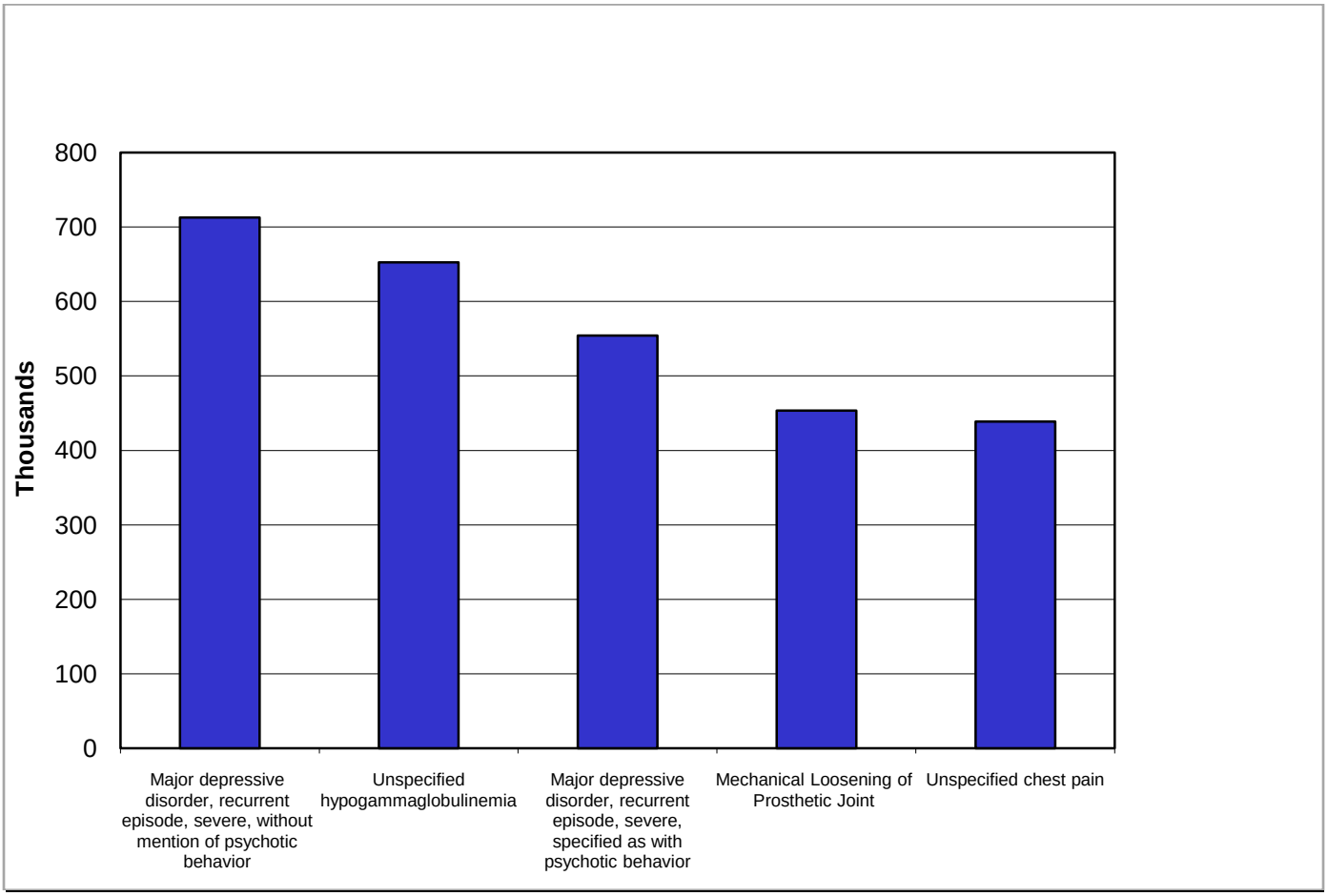


Figure 9: Highest Expenditures by Diagnoses for MediKan Beneficiaries SFY 2008



In the past four fiscal years, few similarities existed for the SSI and MediKan population in relation to their top five diagnoses. The exception is the SSI population had schizoaffective disorder in their top five categories and MediKan had depressive diagnoses in their top five categories. Mental illness is closely aligned with physical illnesses in these population groups.

KHPA receives input from HCK beneficiaries in a variety of ways, providing an indication of beneficiary satisfaction, customer service, and overall program performance. The Quality Assistance Team (QAT) at HP assists with beneficiary and provider inquiries and grievances for both HCK and Medicaid FFS beneficiaries. QAT is composed of nurses, billing and reimbursement specialists, as well as social work staff. Provider and consumer issues from QAT may be referred to HP staff in the Surveillance and Utilization (SURS) department, KHPA program management staff, the Medicaid and Fraud Control Unit (MFCU) at the Kansas Attorney General's Office, state licensing boards, or other regulatory authorities.

KHPA also solicits feedback from HCK beneficiaries through annual surveys administered by the agency's external quality review organization (EQRO), the Kansas Foundation for Medical Care (KFMC). Figures 10-12 provide results from the 2008 HCK Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey with comparisons to the National CAHPS Benchmarking Database. The benchmarks consist of average scores for persons enrolled in public health plans

across the Midwest and the nation. The KHPA website http://www.khpa.ks.gov/ posts the complete CAHPS reports.

Two rating questions reflect overall satisfaction with the care provided at the physician office level. Survey participants were asked to rate their satisfaction with their personal doctor/health provider and specialist on a scale from 0 to 10, where 0 was the worst possible and 10 was the best possible. The scores below represent the percentage of respondents who indicated ratings of either 9 or 10.

Figure 10: Percent of Beneficiaries Giving Personal Doctor/Provider High Rank (9 or 10)

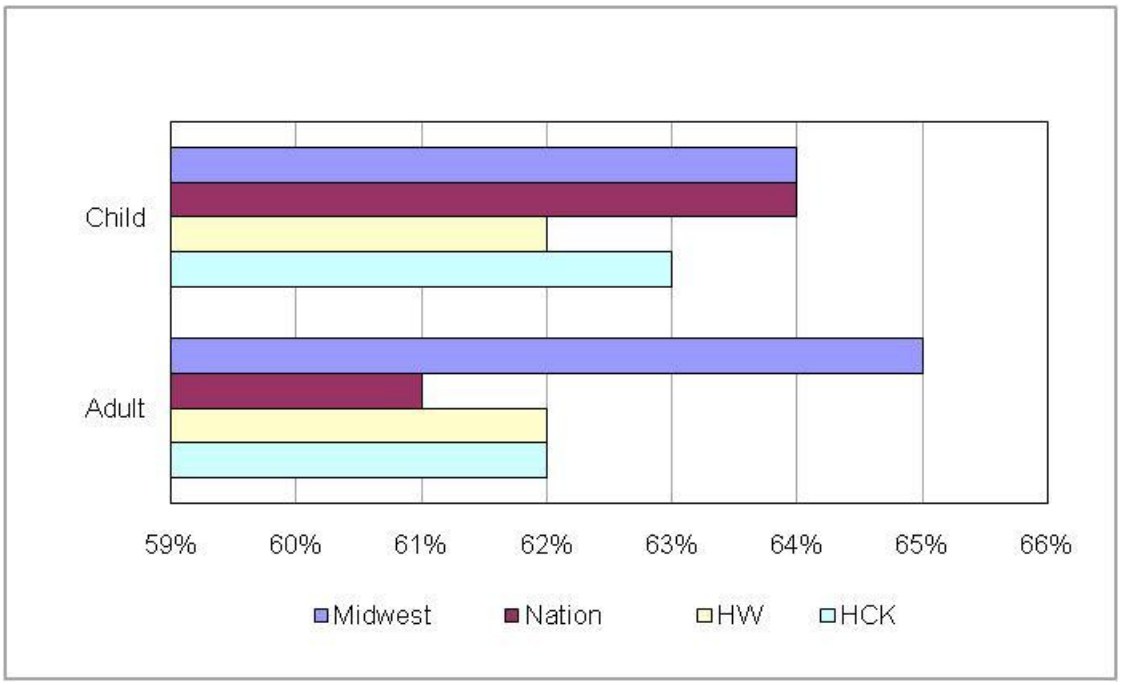
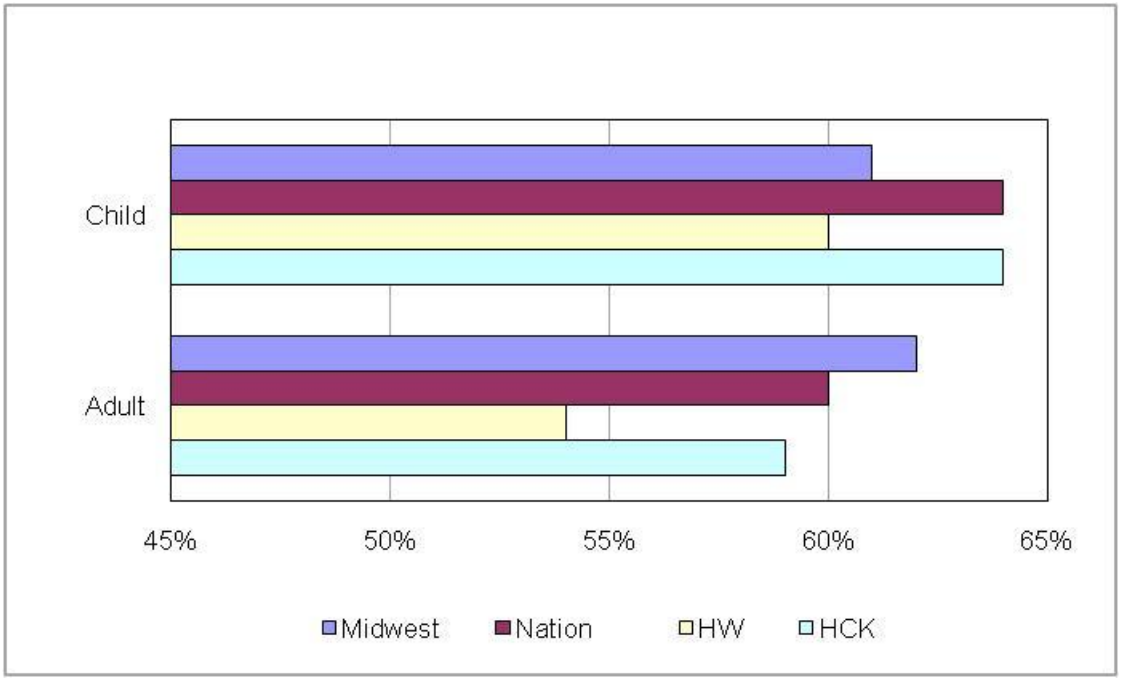


Figure 11: Percent of Beneficiaries Giving Specialist High Rank (9 or 10)



Overall, these comparisons indicate that HCK beneficiaries were very satisfied with their personal doctor/provider and specialist. HCK adults were slightly less satisfied with their personal doctor/provider and specialist than the national and Midwest benchmarks. Parents of children enrolled in HCK expressed levels of satisfaction with their personal doctor and specialist that were equivalent to national and Midwestern benchmarks. HW and HCK adult and child beneficiaries are almost equally satisfied with their personal physician. The HW and HCK networks are similar, since most providers who participate in Medicaid and HCK also participate in HW.

A brochure providing an overview of the CAHPS survey results was sent to all HCK providers in spring 2009. Brochures outlining the CAHPS results have been sent to providers for the last five years but no measures have been in place to monitor improvement or changes to the services delivered to beneficiaries. When future provider workshops are conducted emphasis will be placed on the lowest scoring issues in an attempt to improve beneficiary satisfaction.

KFMC also contracts to make phone calls to providers regarding appointment schedule availability and seven day 24 hour access to care, both elements required by CMS of the HCK program. While some providers need reminders, all providers achieved compliance for providing appointments within mandated CMS time frames and 7 day 24 hour access to medical care. Budget reductions have eliminated HP managed care representatives that were available to follow up with noncompliant providers. As a result the KHPA program manager and the HP managed care team have assumed these responsibilities.

Measuring health plan and provider performance allows Kansas to determine quality of care that beneficiaries are receiving and to pinpoint areas for improvement. Nationally recognized measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) are utilized with a focus in Kansas on children's services provided by the MCOs such as the number of provider visits and immunizations. HEDIS measures are not currently collected in the HCK program.

An evaluation of quality measures that best reflect the needs of the current HCK population should be done and methods for tracking changes and reporting those measures over time implemented. Since the HCK program now primarily serves adults who receive SSI or MediKan selection of different measures would better reflect the quality of care provided to meet HCK beneficiaries' complex needs. In September, 2009, the Center for Health Care Strategies (CHCS) published a technical assistance brief, *Measurement Strategies for Medicaid Beneficiaries with Complex Needs,* including a list of HEDIS measures considered to be appropriate and relevant to assessing care for a Medicaid-only, SSI-eligible adult population. Measures that were identified included:

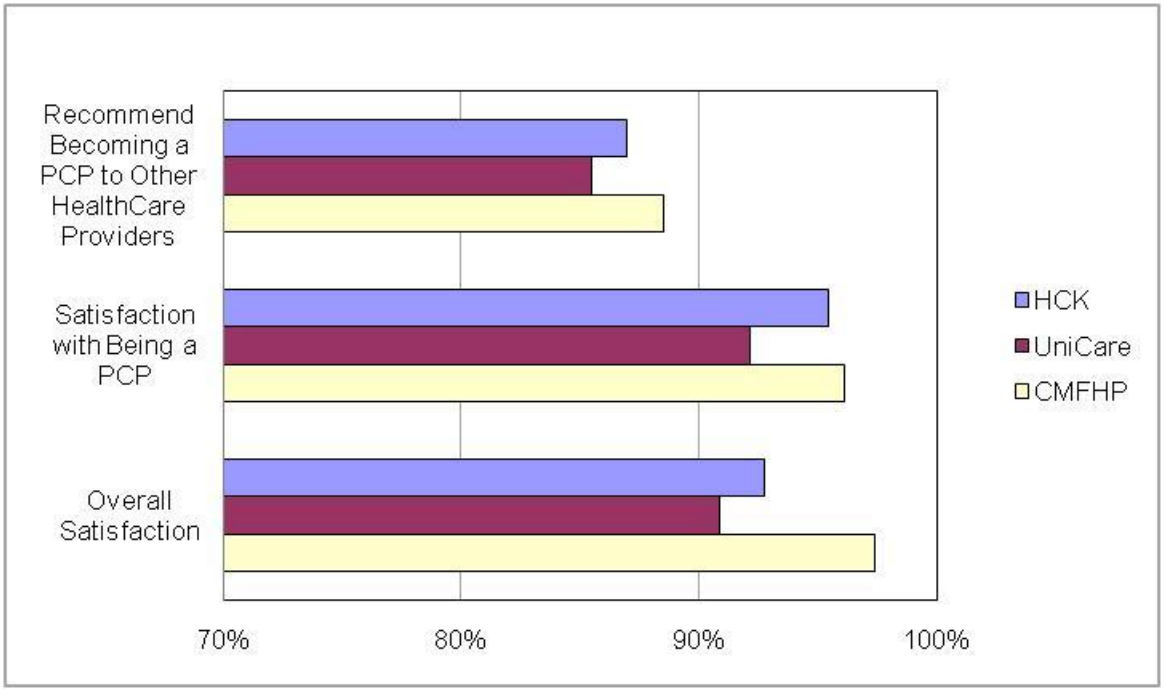
- Controlling high blood pressure
- Comprehensive diabetes care
- Cholesterol management for patient with cardiovascular conditions
- Use of spirometry in the assessment and diagnosis of COPD
- Use of appropriate medications for people with asthma
- Follow-up after hospitalization for mental illness
- Adults' access to preventive/ambulatory health services
- Inpatient utilization (general hospital and acute care)
- Ambulatory care

Implementation of these measures would facilitate analysis of health outcomes for HCK SSI/AD beneficiaries.

KHPA engages providers in a number of ways at the agency and program level to assist in identifying policy issues, administrative concerns, coverage levels, and other programmatic issues. Two sources of information are of particular relevance in the administration of the HCK PCCM program: the Peer Education and Resource Council (PERC) and provider surveys.

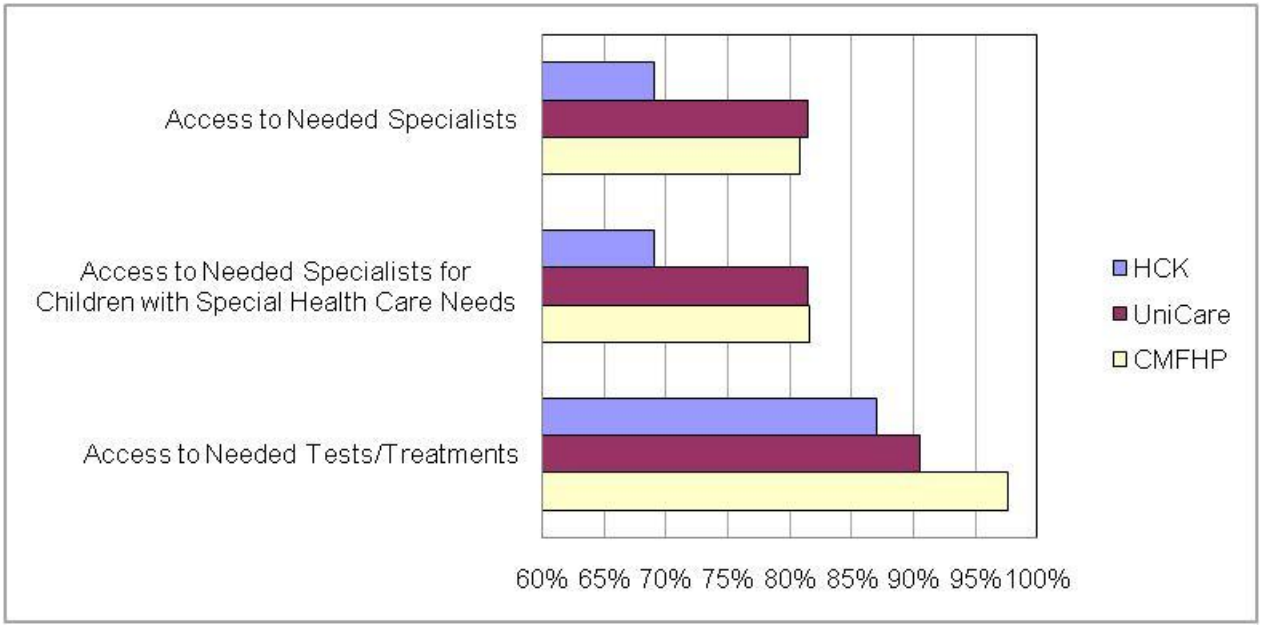
During 2008, KFMC fielded a provider satisfaction survey for HCK and the two managed care organizations, UniCare and Children's Mercy Family Health Partners (CMFHP). This was the first year in which all provider networks received identical provider surveys so that cross-plan comparisons could be made. Each questionnaire had a few plan-specific questions, but all were written in the same manner and analyzed by KFMC. Figure 12 indicates the general satisfaction level providers have with network plans.

Figure 12: Percent of Providers Indicating Satisfaction with Health Plan



Respondents expressed a general satisfaction with CMFHP, UniCare, and HCK, and over 85% would recommend their respective plans to other primary care providers. The satisfaction rates for all three plans are very similar. A noted opportunity for improvement for plans from the provider perspective is increasing the number of specialists available to network participants. This need was evident when looking at Figure 13. HCK satisfaction with access to specialists is notably lower than the two MCOs. In response to the results of the 2008 survey, a comment section was added to the 2009 survey to ascertain the specialists that are less available.

Figure 13: Percent of Providers Indicating Access Difficulties



Program Evaluation

The HCK program was designed as a gatekeeper model to improve access to quality medical services for children and adults. A recent review of a panel hold report indicates there may be access problems for adults in Douglas, Sedgwick, and Shawnee counties. While the panel hold report was helpful in revealing possible access issues in these counties, additional measures that are readily accessible and reliable need to be identified to determine if program objectives are being achieved.

Although originally designed to serve both children and adults, the program now serves primarily adults. Of these adults, approximately 70% are eligible through SSI or MediKan and these are among the highest cost beneficiaries in Kansas Medicaid. The overall trends in expenditures and the implications of chronic health conditions that plague these beneficiaries indicate the need to more effectively manage and support their health care needs. Given the high level of interaction with the medical system to best manage chronic conditions, the need to implement a medical home model of care is significant. Goals for improving care in this population mirror closely the established goals of a patient-centered medical home.

Kansas piloted the ECM program designed as a Chronic Care Model incorporating some components of the North Carolina model. The ECM program was initiated through a contract targeting vendor strengths to address the issue of provider "buy-in". This expectation was critical for successful implementation of the ECM but was not achieved. Primary care providers were identified as the central provider in the ECM program; unfortunately, hospital emergency rooms and mental health networks did not actively engage in the program. In the final year of the pilot however, some primary care providers were communicating with care managers but key partnerships with hospitals, medical providers, and social service agencies were not established. In contrast, in North Carolina and Vermont stakeholders (i.e., hospitals, physicians, social service agencies, and county health departments) participate in the development, implementation, assessment and evaluation of their programs. While Vermont and North

Carolina provide increased provider and PMPM rates the ECM program did not provide these increases.

The ECM pilot program implemented in Sedgwick County from March 2006 through June 2009 was designed to provide care management to chronically ill HCK beneficiaries. An initial evaluation of program expenditures shows the program was costly; over $4 million were expended for 723 people for the term of the project. The net impact of the ECM pilot on Medicaid costs is unknown. Identification of an appropriate comparison group of non-participants is particularly difficult for a voluntary program of this kind, and this makes it very hard to assess any potential reduction in health care costs among those choosing to participate.

Given some of the structural similarities between the PCCM and medical home model, one option for developing a medical home model of care for high-cost, high-need Medicaid beneficiaries in Kansas would be to alter the HCK program. Rather than maintaining the gate keeping process currently in place, the role of the primary care provider could be advanced to one that facilitates and coordinates care; the PMPM fee could be adjusted to reflect the complex needs of the beneficiaries currently being served.

Kansas should consider funding and implementing a pilot program for high-cost beneficiaries to prove the concept of care coordination and to test the impact on health care and spending. The states of North Carolina and Vermont have shown success in programs targeting high-cost beneficiaries. North Carolina has been recognized nationally as a leader in the enhanced medical home model of care. The Department of Health and Human Services announced in September 2009 that Medicare will join Medicaid in Vermont on an initiative that will allow uniform standards to be set for advanced primary care models also known as medical homes. These models provide incentives for providers to spend more time with their patients and offer better coordinated higher-quality medical care. Some key components of the North Carolina and Vermont programs are:

- Key partnerships between providers, hospitals, social service agencies and community agencies
- Increased reimbursement rates
- Targeting high cost, high needs beneficiaries
- Data monitoring and reporting for continuous program improvement.

The PMPM payment for the medical home model for the SSI/AD population is enhanced in North Carolina and Vermont. If Kansas were to tailor a medical home model based on North Carolina or Vermont's model, consideration would need to be given to the PMPM rate.

In North Carolina, monthly payment is made to both providers and networks: $2.50 is paid to the PCCM; $3.00 goes to the network for case managers and pharmacists. If the client is in the AD population the PCCM is paid a $5.00 PCCM fee.

In Vermont, payment is made to both the coordination team and providers: $15 for the care coordination team per month; the PCCM receives $55 for meeting with the care coordination team to develop a plan of care, $55 for a discharge meeting to emphasize the importance of a smooth transition to a lower level of care in the program and an additional $10 PMPM fee on top of their normal PCCM fee.

In North Carolina and Vermont, PMPM payments are made to other stakeholders such as hospitals, pharmacists, and/or the case manager network so monies would be needed to support PMPM payment to these providers.

During the 2008 legislative session House Substitute for Senate Bill 81 (SB 81) was passed and this legislation defined a medical home in Kansas statute. SB 81 instructed KHPA to incorporate the use of the medical home model into Medicaid, HealthWave and the MediKan program and the state employee health benefit plan. With the passage of SB81, stakeholder meetings were held across the state with key stakeholders evaluating the applicability of national medical home principles and standards, developing potential pilot projects, and soliciting feedback from primary care providers and consumers throughout the state. A preamble was drafted and is included as Appendix A at the end of this document.

Medical homes can be supported by an enhanced infrastructure that includes health registries and health information exchange. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA), authorized roughly $36 billion in federal competitive grants over six years for Health Information Technology (HIT) and Exchange (HIE). HITECH requires the implementation of a policy framework to support the design, development and operation of a nationwide HIT infrastructure to allow the electronic use and exchange of health care information with the goal to avail each U.S. citizen an electronic health record by 2014. Kansas began working on securing this funding in 2009. The Kansas Department of Health and Environment is responsible for the grant proposal and has convened a steering committee with interested agencies and stakeholders to craft the proposal with the goal of improving care coordination and health outcomes. ARRA funding will advance health care coordination and improve health outcomes. ARRA funding is also available to qualified health care providers for the purchase and use of electronic health records (EHR). Eligible providers include non-hospital providers with 30% of their client volume attributed to Medicaid and acute care hospitals with at least 10% Medicaid volume. From 2011 to 2015 incentive payments will be available to providers demonstrating "meaningful use" of certified EHRs.

During September 2009, Kansas was selected by NASHP as one of eight states to form participate in a "Consortium to Advance Medical Homes for Medicaid and CHIP Participants." With the support of NASHP, through a grant from the Commonwealth Fund, the states will work together to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes. Technical assistance will be provided for a period of one year to support the states' efforts. Experts, including mentors from the leading states, will help the consortium understand their policy options and develop/refine their plans for achieving five key policy goals: develop key partnerships, define and recognize medical homes, improve purchasing and reimbursement policies, support practice change, and measure progress.

In addition to considering the North Carolina and Vermont programs, other programs and interventions that have been effective in providing services to beneficiaries with complex health needs should be considered. For example, based on research of Medicare consumers by Mathematica, completed in 2009, "*The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Beneficiaries with Chronic Illnesses",* three types of interventions for clients with chronic illnesses have proven effective.

1. Transitional care interventions which engaged consumers while hospitalized by nurse practitioners. Intensive post-discharge and time-limited follow-up was provided to the

client along with comprehensive post-discharge instructions on medications, self-care, and symptom recognition and management. Reminders for follow-up appointments were also provided.

2. Self-Management education interventions where medical staff collaborates with clients and their families to identify individualized client goals, improve self-management skills, and expand a sense of self-efficacy. Group sessions focusing on exercise, symptom management techniques, nutrition, fatigue/sleep management, medications, communication, problem-solving skills and dealing with emotions are offered on a time-limited basis.

3. Care coordinated interventions which provide clients with education on medications, when to seek medical care, proper self-care, communication skills and available social supports. The client's symptoms, well-being and compliance with medical recommendations is monitored and reported to their health care providers. Health-related social services are arranged for clients and communication among all the client's health care providers is facilitated.

The full report, *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Beneficiaries with Chronic Illnesses,* (May 2009) may be found by visiting http://www.socialworkleadership.org/nsw/Brown_Full_Report.pdf.

Along with examining best practices, potential partners could be identified through a request for information (RFI) released by the state. The RFI could be used to solicit suggestions, ideas or potential approaches, and to determine the availability and level of interest, in developing the pilot. Program evaluation would need to be built into the pilot to measure quality, efficiency, and effectiveness and to ensure a positive return on investment (ROI).

Recommendations

1. Conduct stakeholder meetings to obtain input from HCK PCCM providers regarding the implementation of a medical home model. Feedback provided should be used to determine preliminary interest and feasibility of modifying the program to support a medical home model of care for HCK beneficiaries.

2. Consider implementing a pilot program to test chronic care management strategies in practice settings with a high volume of SSI/AD beneficiaries. The completed Kansas Medicaid Transformation Grant (Health Promotion for Kansans with Disabilities) found substantial deficiencies in preventive care and chronic disease management for disabled beneficiaries and recommended the development of effective approaches to managing health care and outcomes for people with disabilities. The results of this project support the need for development of a coordinated model of care for medically complex beneficiaries.

3. Implement HEDIS-like measures that have been identified as appropriate and relevant to evaluating care for a Medicaid-only, SSI-eligible adult population. The Data Analytic Interface (DAI) system has built-in HEDIS-like measures that focus on asthma, diabetes, low back pain, and follow up care after mental health hospitalizations. These DAI measures should be collected for the SSI Medicaid population to analyze health outcomes for HCK SSI/AD beneficiaries.

4. Develop a state-wide report to determine the distance HCK beneficiaries are traveling to see their PCCM. This report will be compared to the HP panel hold report to help assess access issues HCK beneficiaries are experiencing. DAI is able to calculate the distance between the HCK PCCM and the assigned beneficiary.

5. Develop a statewide provider listing of specialists in highest demand by HCK beneficiaries, based on the results of the 2009 CAHPS, and send to HCK providers and beneficiaries.

APPENDIX A: Kansas Medical Home Model Draft Preamble

The development of a person-centered medical home model to transform the delivery of health care services is supported by multiple stakeholders across Kansas. The designation of the medical home is a cornerstone of reforming the health system in our State. During the 2008 Kansas legislative session, House Substitute for Senate Bill 81 defined the Kansas medical home in statute as:

"a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner."

In Kansas, we recognize that a medical home model must emphasize coordination of care between all health providers. The role of the KHPA is to facilitate the development of a medical home model for Kansas consumers/patients that would promote accountability, coordination and communication among providers by encouraging providers in different settings – physician offices, inpatient hospitals, post-acute care settings, safety net clinics, pharmacies, and others – to collaborate and provide patient-centered care in ways that would improve health outcomes, promote quality of care, and control rising health care costs.

Building on and from the *Joint Principles of the Patient-Centered Medical Home*, a model for the medical home in Kansas must be tailored to our unique demographic and geographic profile. The Kansas model will encompass the roles of physicians (both primary and specialist), midlevel practitioners, nurses, mental health providers, optometrists, podiatrists, dentists, therapists, pharmacists, and others. The medical home in Kansas should recognize the importance of mental health services and the relationship between physical, oral and mental health. In addition, addressing the appropriate setting and continuum of care from prenatal care and birth to death is essential to optimal functioning of the medical home.

The medical home in Kansas should build on the research and findings from national leaders but acknowledge the challenges and opportunities in creating a medical home in rural and urban underserved communities in Kansas. In addition, the development of a medical home in Kansas should align with national medical home model initiatives, include provider payment reforms, emphasize increased patient-provider communication and advance health information technology and exchange (to include telemedicine and telehealth) as a tool to improve coordination of care and health outcomes. Improving the coordination of health care is a key component of a medical home model and the utilization of health information technology and exchange is a primary means to improve coordination and critical to transforming medical practices and our entire health care delivery system.